TABLE OF CONTENTS

1. INTRODUCTION

A. OVERVIEW

All providers will complete a cost report using the prescribed format for a twelve-month period. The purpose of the cost report is to define the cost of each service by service center. The cost report is comprised of Schedule A - Expenses and Schedule B - Revenues, along with Attachment One. The horizontal axis of the cost report depicts all service centers as well as the "Total" and "Adjustment" columns. The vertical axis represents various accounts. Schedule A has a Chart of Accounts unique to Schedule A and Schedule B has a Chart of Accounts unique to Schedule B. The cost report must be completed on an accrual basis of accounting.

Information to complete the cost report may come from various sources depending on each agency's method of tracking costs. Personnel, payroll, provider expense records, and activity logs are examples of tools that may be used to compile information to complete the cost report.

B. GENERAL GUIDELINES

1. Deadline: The deadline for returning the required annual cost report to the Department is four months after the provider's fiscal year-end. All incomplete or incorrect reports will be returned to the provider for corrections. Corrections to the cost report are to be made by the provider and resubmitted to the department within 30 days of the initial inquiry.

2. Contents: The complete annual cost report includes: Schedules A and B, Attachment One and Notes to Schedules A and B. These forms will cover the agency's twelve-month fiscal year.

3. Method of Submission: Schedules A and B and Notes to Schedules A and B shall be included in the annual entity wide audit as prescribed in Sections 3 and 4. Schedules A and B, Notes to Schedules A and B and Attachment One shall be submitted directly to the Department of Social Services (and Department of Human Services if applicable) via mail or email.

4. Use of columns: A separate column shall be used for each service center. Select the applicable service center heading from the dropdown box in Row 5 in the appropriate section.

5. Use of lines: Report expenses and revenues on the appropriate line based upon the nature of the item.

6. Supporting Documentation: All expenses and revenues reflected on these forms must be supported by the provider's general ledger. Worksheets or an explanation that reasonably justifies the entry must support adjusting journal entries. All records and worksheets used in preparing the reports must be readily available for audit.

7. Rounding: All costs reported on Schedule A are to be gross costs and rounded to the nearest whole dollar no cents should be reported.

8. Adjustments: The Adjustment Column may be used to report items included in the audited Financial Statements that may not be allowable expenses or reportable revenues to service centers.

C. FINANCIAL REPORTING REQUIREMENTS

1. **Records**

   a. The provider shall maintain on the premises the required service records and financial information sufficient to provide for a proper audit or review, including documentation to support the rationale for direct assignment to specific service centers or the allocation to numerous service centers. Sufficient data must be available as of the audit date to fully support any item being claimed on the cost report.

   b. Accounting or financial information regarding related organizations must be readily available to substantiate cost.

   c. Records must be retained for six years following the submission of the cost report. Records relating to unresolved audits must be retained until final resolution of the audit. Records must be available upon reasonable demand to representatives of the Department and/or Attorney General's Medicaid Fraud Unit and/or to the US Secretary of Health and Human Services or representatives thereof.

2. **Accounting and Reporting Requirements**

   a. The accrual basis of accounting must be used for reporting purposes.

   b. The accounting system must be structured so that cost accounts are grouped by service center and traceable to the cost report.

   c. Generally accepted accounting principles must be followed unless the Department specifies alternative treatment.

   d. Costs reported must include all actual costs and adjustments for non-allowable costs. The Department will forward all items identified as fraudulent or abusive to the Attorney General’s Medicaid Fraud Unit.

   e. Costs must be allocated by the method identified in the guidelines for Schedule A – Expenses for services used for more than one operational program, administration or non-allowable activity. DD providers only: During reporting periods where activity logging is not required, time study or an alternate method of allowable allocation must be performed.

f. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Generally accepted accounting procedures will be used in determining the life of any addition(s) to primary structures.

g. Depreciation on fixed equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item(s) purchased after January 1, 1987.

Depreciation on major movable equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method, following the AHA Guidelines for any item purchased after January 1, 1987. Deviations from AHA Guidelines may be granted in those instances in which providers can furnish the Department with documented historical proof of useful life.

h. Funded Depreciation Accounts

1. A funded depreciation account can be established for the replacement of capital assets and can be funded at a rate not greater than current annual depreciation.

2. The establishment of the fund and the procedures governing the fund must be specifically approved by the provider's board of directors.

3. The approved procedures must stipulate the rate by which the account will be funded and shall delineate the items to be purchased with the fund.

4. Providers must use the account for the purchase of capital items as defined by their internal procedures. Transfers from the funded depreciation reserve account will be allowed for necessary cash flow purposes as long as the transfer does not cause the agency to exceed operating reserve standards set forth in the Cost Report Preparation Guidelines (see Reserve Funds policy, page 7).

5. Providers with funded depreciation accounts shall use the following format for their annual audited financial statement. Funded depreciation accounts will be recorded:

a. in the Assets section under the heading "Designated for Capital Asset Replacement". The amount may appear in various places in the Assets section depending on whether the money is in a checking account, Money Market fund, CD's, Time Deposits, etc. or

b. in the Unrestricted Net Assets section under the heading "Designated for Capital Asset Replacement".

i. No reimbursement shall be allowed for additional costs related to sub-leases.

3. **Auditing**

The provider shall have an annual entity-wide independent audit covering the same reporting period as the cost report. Worksheet entries reconciling the cost report to the audit shall be prepared either by the provider or the auditor and shall be included with the cost report (see Page 25, Notes to Schedule A and Notes to Schedule B). The audit shall be submitted to the Department of Human Services.

A-133:
If applicable, audits shall be conducted in accordance with OMB Circular A-133 by an auditor approved by the Auditor General to perform the audit. Approval may be obtained by forwarding a copy of the audit engagement letter to:

Department of Legislative Audit A-
133 Coordinator
427 South Chapelle
c/o 500 East Capitol
Pierre, SD 57501-5070

On continuing audit engagements, the Auditor General's approval should be obtained annually. Audits shall be completed and filed with the Department of Legislative Audit by the end of four months following the end of the fiscal year being audited.

Failure to complete audits as required will result in the disallowance of audit costs as direct or indirect charges to programs. Additionally, a percentage of awards may be withheld until the audit is completed satisfactorily, overhead costs may be disallowed, and/or awards may be suspended until the audit is made.

4. **Submission of Audit:**

a. A copy of the completed audit report shall be provided to the Department by the end of four months following the end of the fiscal year being audited.

b. The cost report shall be tested by an independent auditor and a statement indicating such should be included in the audit report.

c. Cost Report forms (Schedules A and B) shall be included in the paper audit report, Supplementary section, and shall also be submitted to the

Department electronically via email. Testing requirements for sub-categories on Schedule A are as follows:

1. Personnel Services: If expenses charged to this area of the cost report (Total column, TOTAL PERSONNEL SERVICES) are 65% or greater of total agency expenses on Schedule A, the sample test size shall be 10 employees. Of these two (2) shall be Administrative staff and eight (8) shall be Professional staff. If expenses charged to this area of the cost report are less than 65% of total agency expenses, the sample test size shall be five (5) employees. Of these one (1) shall be Administrative staff and four (4) shall be Professional staff.

2. Personnel Benefits and Taxes: Test allocations for the same employees selected for Personnel Services testing.

3. Professional Fees and Contract Services: If expenses charged to this area of the cost report (Total column, TOTAL PROFESSIONAL FEES AND CONTRACT SERVICES) are 6% or greater of total agency expenses on Schedule A, the sample test size shall be six (6) transactions. If expenses charged to this area of the cost report are less than 6% of total agency expenses, the sample test size shall be three (3) transactions.

4. Travel/Transportation: If expenses charged to this area of the cost report (Total column, TOTAL TRAVEL/TRANSPORTATION) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

5. Supplies: If expenses charged to this area of the cost report (Total column, TOTAL SUPPLIES) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

6. Occupancy: If expenses charged to this area of the cost report (Total column, TOTAL OCCUPANCY) are 7% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 7% of total agency expenses, the sample test size shall be one (1) transaction.

7. Equipment: If expenses charged to this area of the cost report (Total column, TOTAL EQUIPMENT) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3)

transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

8. Depreciation: If expenses charged to this area of the cost report (Total column, TOTAL DEPRECIATION) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

9. Miscellaneous: If expenses charged to this area of the cost report (Total column, TOTAL MISCELLANEOUS) are 5% or greater of total agency expenses on Schedule A, the sample test size shall be three (3) transactions. If expenses charged to this area of the cost report are less than 5% of total agency expenses, the sample test size shall be zero (0) transactions.

5. **Filing Extensions**

a. No automatic extensions for filing of the annual cost report or audit report will be made. All requests **must** be in writing and **must** be received by the Department at least 10 working days prior to the due date.

b. Requests must clearly explain the reason for the extension and identify the date on which the report will be submitted.

c. Approval of extensions will be granted for good cause at the sole discretion of the Department. The provider will be notified in writing of the approval or denial. A "good cause" is one that supplies a substantial reason, affords a legal excuse for the delay, or an intervening action beyond the provider's control. The following are not considered "good cause": ignorance of the rule, inconvenience, and/or a cost report preparer and/or independent public accountant is engaged in other work.

d. Amendments to reported costs will not be allowed after the cost reports have been used to determine rates.

6. **Reserve Funds Policy**

Reserve funds (excluding restricted trust or endowments, and/or funded depreciation accounts) shall not exceed 90 days total operating expenses. The Department calculates agency reserves using information reported in the annual independent audited financial statements. The formula for calculating reserves is: Reserves = (Unrestricted Funds – Funded Depreciation and Endowments). Sinking funds specifically reserved for building or equipment replacement may be excluded to the extent it was accumulated at the authorized depreciation rate (see

Accounting and Reporting Requirements, page 3). If reserves exceed 90 days total operating expenses, the provider must submit a plan to the Department for re-investing the excess into the program. The Department will notify the provider of approval or disapproval within 30 days.

7. **Recording of Service Units**

The provider must maintain a record of all service units as required by the Department.

8. **Cost Allowability and Limitations**

Any questions regarding cost allowability and limitations will be governed by Title XIX of the Social Security Act unless further limited by these guidelines or the purchase of service agreement.

9. **Unallowable Costs**

Unallowable costs include, but are not limited to, the items listed below. For further clarification, please refer to the Office of Management and Budget (OMB) Circular A-122 at http://www.whitehouse.gov/omb/circulars/a122/a122_2004.html or the CMS Pub. 15 (Centers for Medicare and Medicaid Services, Provider Reimbursement Manual at http://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Paper-Based-Manuals.html

a. Advertising, public relations, and clothing expenses as identified by OMB A-122. Allowable costs include, but are not limited to, costs associated with the recruitment of personnel, yellow page ads, and advertising of specific services (i.e. 24-hour emergency line). Unallowable costs include, but are not limited to, promotional items, advertising and informational campaigns designed solely to promote the agency.

b. Costs which have not been incurred by the agency, including the value of donated goods and services.

c. Bad debt is a deduction from the applicable Service Center rather than a reimbursable expense item and should be reported in the adjustment column. Bad debts, and costs arising from uncollectible accounts and related collection costs, are unallowable.

d. Costs incurred solely to enhance income from investments.

e. Cost of securing contributions or donations.

f. Costs for idle facilities except when such facilities are necessary to meet caseload fluctuations.

g. Costs of membership to a country club, social or dining club or organization is unallowable.

h. Costs of fines and penalties resulting from violations of, or failure to comply with Federal, State and local laws and regulations are unallowable.

i. Finance, late charges and the following items of interest expense are not reimbursable:
   1. Funds borrowed for investment purposes;
   2. Funds borrowed to create working capital in excess of two months operating costs;
   3. Funds borrowed for the personal benefit of employees, officers, board of directors, members, or owners of the provider agency;
   4. Funds borrowed without a prior time-limited written agreement with the Department for the purchase of land or buildings, until such items are actively used in program activity; and,
   5. Interest charges made for intra-agency loans between funds are not a reimbursable expense. An agency is defined as an organizational entity with a single Federal Employer's Identification Number.

j. Employee morale, health and welfare:
   1. **Parties/picnics** – The costs associated with staff holiday parties, picnics or similar social activities are unallowable. The costs for such parties or events that staff and consumers attend together are allowable.
   2. **Flowers/gifts** – The cost of flowers and gifts for staff is unallowable.
   3. **Awards** – The cost is allowable if the item is used to recognize employee achievement or performance (productivity, safety, longevity, etc).
   4. **Recreational activities** – The costs of provider sponsored employee sports teams and employee organizations designed to improve company loyalty, team work, or physical fitness are allowable.

k. Taxes (see page 11, **a. Taxes**).

l. Telephone costs attributable to personal use by employees and consumers.

m. All costs associated with payment to registered lobbyists.

n. Costs associated with charity, grants, and professional discounts. Charity is defined as the donation of cash or in-kind services to other organizations

and individuals external to the provider. Grants are defined as awards to organizations, programs and/or individuals external to the provider.

o. Meals consumed by guests and staff when staff attendance with the consumer is not programmatically mandatory. This does not prohibit this expense for live-in staff. Meals are allowable as part of required travel for staff.

p. Costs of selling and marketing any products or services of the organization (example: production).

q. Cost of car reserved only for agency director.

r. Costs associated with depreciation of equipment/buildings obtained with monies (i.e., grants, for example Department of Transportation) not allowing subsequent year's depreciation.

10. **Parent-Subsidiary/Related Organizations (Specify on Attachment A)**

a. Costs applicable to services, facilities, and supplies furnished to a provider by a parent-subsidiary/related organization, shall not exceed the lower of the cost to the parent-subsidiary/related organization or the price of comparable services, facilities, or supplies purchased elsewhere, primarily in the local market. Providers must identify such parent-subsidiary/related organizations and costs in the cost report and include an appropriate statement of costs and allocations with the cost report. Umbrella or chain organizations are also considered parent-subsidiary/related organizations. Management fees will be considered administrative costs for cost reporting purposes.

b. Home offices of parent-subsidiary/related organizations vary greatly in size, number of locations, staff, and services furnished to their member facilities. Although the home office is normally not a provider in itself, it may furnish to the individual provider central administration or other services, such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual cost of providing such services may be included in the provider's allowable costs under the program. In order to be considered an allowable cost, the home office costs must be directly related to those services performed for individual providers and relate to consumer services. Documentation as to the time spent, the services provided, the hourly valuation of services, and the allocation method used, must be available to substantiate the reasonableness of the cost. Any services provided by the home office which are included in costs as payments to an outside provider, will be considered a duplication of costs and not be allowed.

c. Rental expense for buildings and equipment that do not exceed actual cost for these items and that are necessary to provide program services to recipients, are an allowable expense.

11. **Gifts and Income from Endowments**

a. Unrestricted gifts and income from endowments will not be deducted from operating costs in computing reimbursable cost. Gifts or endowment income designated by a donor for paying specific operating costs incurred in providing contract services will be deducted from the particular program operating cost or group of costs.

b. The terms of the contribution may specifically state the period of time during which the funds are to be applied. When specific periods of time are not provided, restricted contributions are deemed to be used in the reporting period in which the gift is received to the extent that applicable costs are incurred after the date of the gift. Generally, the donor of a restricted contribution intends that the provider use the funds for the purpose for which they were given; therefore, the above order of application is in accord with the purposes of the gift. Restricted contributions not used in the reporting period in which they were received are carried over into the following period, or periods, and used for the designated purpose.
Assume that a provider incurred $10,000 cost for transportation services during a calendar year reporting period. On July 1, they received a contribution of $10,000 which was designated by the donor to be used to provide transportation services for all consumers. Examination of the costs of these services indicates that costs of $4,000 were incurred after July 1. Under the principles of reimbursement, allowable costs shall be computed as follows:

Total costs of transportation services for the period	$10,000
Portion of costs incurred after date of gift (July 1)	4,000
Allowable costs for the reporting period	$ 6,000

The amount of restricted contribution would be adjusted as follows:

Contribution as of July 1	$10,000
Appropriate costs incurred subsequent to date of gift	4,000
Balance of restricted contribution at end of reporting period.	$ 6,000

The balance would be applied to the costs incurred for transportation services during the subsequent reporting period(s).

12. **Taxes**

a. Taxes assessed against the provider, in accordance with the levying enactments of several states and lower levels of government and for which the provider is liable for payment, are allowable costs.

b. The following taxes are not allowable as costs:

1. Federal income and excess profit taxes, including any interest or penalties paid.

2. State or local income and excess profit taxes.

3. Taxes in connection with financing, refinancing, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not recognized as tax expense.

4. Taxes from which exemptions are available to the provider.

5. Special assessments on land which represent capital improvements, such as sewers, water and pavement should be capitalized and may be depreciated.

6. Taxes on property which is not used in the provision of covered services.

7. Tax expense may not include fines or penalties.

8. Self-employment taxes.

2. COST REPORT: SCHEDULE A - EXPENSES

Columns and rows highlighted in gray (on the templates) are completed by DHS staff.

A. HORIZONTAL AXIS: TOTAL AND ADJUSTMENT COLUMNS/SERVICE CENTERS

Please enter the facility name and the reporting period in cells B1 and B2 respectively. This information will transfer automatically to subsequent sheets within the cost report workbook.

The horizontal axis contains the Total, Adjustments, Administration and Support and Fund Raising columns as well as the program services unique to each provider group (Division of Mental Health, Division of Alcohol and Drug Abuse, Developmental Disabilities and Rehabilitation Services). Following is a list of definitions for the Total, Adjustments, Administration and Support, Fund Raising and Other Services columns. You can find a list of the program services for Division of Mental Health**,** Division of Alcohol and Drug Abuse**,** Developmental Disabilities and Rehabilitation Services in Appendices A, B, C and D.

Total - This column represents the total expenses from the operating statement of the organization for the reporting period. The total of the expenses must reconcile to the independently audited financial statements.

Adjustments - This column represents additions or deletions from the total column for costs that do not represent a cost to a service center or are considered unallowable **(see list of Unallowable Costs on pages 8-10)**. Provide an explanation of any amounts reported in this column on the Notes to Schedule A.

Administration and Support – This column represents expenditures for the overall direction of the organization, general record keeping, business management, budgeting, general board activities, and related purposes. Direct supervision of program services and of fund raising should be charged to those functions. Overall direction will usually include the salaries and expenses of the chief officer of the organization and his/her staff. If they spend a portion of their time directly supervising fund-raising or program services and activities, such salaries and expenses should be prorated among those functions.

Fund Raising – Expenditures normally charged to this function include costs of transmitting appeals to the public (including postage, addressing, maintenance of mailing lists and other fund drive records) and the salaries of staff members connected with fund raising for the agency, capital campaigns, foundations, etc. An appropriate portion of the salaries of regular staff members who devote time to record keeping for fund raising should be allocated to fund raising expenses.

Other Services - Use these columns for reporting expenditures for services other than those listed in Appendices A and B. Report expenditures associated with services not purchased by the Division of Developmental Disabilities, Division of Rehabilitation Services.
Please Note: Do not include special program (special rate) expenditures in this column. These costs should be included under the appropriate service center with the regular costs.

B. VERTICAL AXIS - CHART OF ACCOUNTS

Costs should be allocated by direct assignment to Administration and Support or the benefiting service center based on time study or activity logging unless otherwise indicated.

1000 - PERSONNEL SERVICES

1010 - **Administrative:** Personnel who manage/direct the overall or specific programs of the agency, make policy decisions, provide training and do not spend more than 10% of their time providing direct service. If an individual spends more than 10% of their time providing direct service, they should be listed under 1020 – Professional/Program Staff.

Examples:

President/CEO	Finance Director
Executive Director	Business/Office Manager

1020 - **Professional/Program Staff:** Personnel who may be certified or licensed to provide services related to their profession and are necessary to provide basic program services.

Examples:

Social Worker	Job Coach
Counselor (CCDC, MH, DD, REHAB, etc.)	Physician
Registered Nurse	Licensed Practical Nurse
Teacher	Staff Development
Residential Instructors/Aids	Supported Living Instructors

1040 - **Support Staff:** Personnel who do not provide direct service to individuals served, but support the daily operations of the agency.

Examples:

Office Staff (Admin. & Support)	Custodial Staff (Sq. Ft. or Direct)
Adaptive Equipment Specialist	Nursing Secretaries

1050 - Consumer Wages: Wages paid to consumers for work performed in or for the facility (direct assignment to Production or benefiting service center). *Note: Hours and wages for these individuals should not be reported on Attachment One.*

Example: Wages paid for in-house janitorial work would be reported under the appropriate service center based on square footage.

1060 - Temporary Staff: Personnel hired for a temporary period of time. The personnel costs associated with these individuals are reported on Schedule A. *Note: Hours and wages for these individuals should not be reported on Attachment One.*

Examples:

Staff hired to fill-in or cover for administration or support staff on maternity leave, FMLA, extended disability, etc.

Staff hired for a short-term project. These staff are supplements to existing staff and do not provide direct care (i.e. staff hired to do production work along side people served in a workshop to meet production deadlines, staff hired for a grant position that is short lived and will not continue, or staff to provide summer maintenance/yard work).

Staff hired as on-call or relief direct care staff. These staff fill-in when a full-time direct care staff uses vacation or sick leave or other times as needed (i.e. additional staff needed due to illness or behavior of people served). The number of on-call staff and the hours available for them to work varies at any point in time.

1090 - Payroll Accruals: Effective FY09, payroll accruals will not be reported to a separate account. Include all personnel expenses, both paid and accrued, on the appropriate line (line 1010, 1020, 1040, 1050 and 1060).

1100 - PERSONNEL BENEFITS AND TAXES

1110 - Retirement Plans: The cost of agency contributions to employee retirement plans.

1120 - Insurance Benefits: The cost of items such as health, life, disability and dental insurance coverage for agency staff.

1130 - Other Benefits: The cost of employee benefits which are not included above. Examples include childcare, educational benefits, staff appreciation (other than wages), employee physicals, Hepatitis B and TB testing. Provide an explanation of any amounts reported in this account on the Notes to Schedule A.

1140 - FICA Taxes: Represents the FICA tax expense to the agency, to include Medicare amount.

1150 - Unemployment Insurance: The cost of State and/or Federal unemployment insurance.

1160 - Worker's Compensation Insurance: Represents the agency's Worker's Compensation Insurance premium.

1170 - Professional Liability Insurance: Represents the cost of liability insurance premiums related to coverage for actions/omissions of employees and/or board members (protection against fraudulent or dishonest acts by officers or employees).

1190 - Other: If the amount reported in the total column for this account equals or exceeds 5% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes to Schedule A.

1200 - PROFESSIONAL FEES & CONTRACTUAL SERVICES

Services obtained from non-agency professionals in each of the following areas.

1210 - Administrative/Financial: Represents the cost of financial, accounting or data processing professionals, including software support agreements. Includes the following:

Audit Services: Represents the cost of an independent audit of the agency. *Direct assignment to Admin. & Support*

Legal Services: Represents the cost of attorney or legal services. *Direct assignment to Admin. & Support for personnel or property; otherwise direct assignment to benefiting service center*

Advertising/Public Relations: Represents the costs associated with allowable advertising and public relations, such as the recruitment of personnel and yellow-page ads. See pages 8-10 (Unallowable Costs) for additional information. *Example: Fund raising to Fund Raising, advertising for a position to the benefiting service center*

Dues/Memberships/Subs./Ref. Materials: Represents amounts paid for membership in organizations, costs for subscriptions, and reference and resource publications purchased for use by the agency. *Example: Physician's Desk Reference to Nursing Services, SDACBS to Admin. & Support, Council of CMHC Directors to Admin & Support*

Registration Fees: Represents the registration costs of conventions, conferences and meetings.

1220 - Habilitation/Rehabilitation: Costs associated with services obtained from non-agency professionals such as a special education teacher, certified vocational evaluator, psychologist, recreational therapist and social worker.

1231- Other Medical: Costs associated with services obtained from non-agency professionals for the following: Dental, Dietary, Occupational Therapy, Physical Therapy, Optometric, Pharmacy, Speech Pathology and Audiological Services.

1237 - Physician/Nursing Services: Costs associated with physician and nursing services obtained from non-agency professionals (including the cost of lab reports).

1238 - Psychiatric Services: Costs associated with psychiatric services obtained from non-agency professionals.

1290 - Other Professional Services: Costs for services obtained from non-agency professionals not identified in accounts 1210 through 1238. Examples include architectural or engineering services, costs incurred with outside speakers, meals, motels, fees, etc.
Please Note: If the amount reported in the total column for this account equals or exceeds 20% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes to Schedule A.

1300 - TRAVEL/TRANSPORTATION

1390 - Other: Represents the cost of mileage payments to staff, consumers (token/tickets), board members, volunteers, transportation providers and others and the cost of repairs, maintenance, insurance, lodging, meals and other travel costs. Examples include short-

term rentals for automobiles, parking fees, airfare, bus or taxi fares, and mass transit. Report principal payments related to the purchase of vehicles and lease payments meeting capitalization guidelines in the 1700 series. **Please Note:** If the amount reported in the total column for this account equals or exceeds 10% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes to Schedule A.

1400 - SUPPLIES

1440 - Food: Represents all costs associated with the purchase of consumable foods and related dietary items such as nutritional supplements. This includes the value of commodities. Report nutritional supplements under the Medical Equipment and Drugs service center. *Direct assignment to Food Service or benefiting service center*

1490 - Other: Represents other supply costs such as office, program/instructional, medical, postage and shipping, and production. **Please Note:** If the amount reported in the total column for this account equals or exceeds 10% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes to Schedule A.

1500 - OCCUPANCY

1510 - Rent of Space: Cost of rental payments for land, buildings, office, or residential space used for the operation of the agency. *Direct assignment to benefiting service center based on square feet*

1520 - Utilities & Telephone: The cost of a public service, unless the cost is included in rent. Utilities include heat, lights, water, gas, electricity, waste removal, and cable TV (*direct assignment to benefiting service center based on square feet)*. Telephone includes the cost of monthly service and long-distance fees (*direct assignment to benefiting service center for monthly service and long distance per phone).*

1590 - Other: The cost associated with mortgage interest, insurance, taxes, buildings and grounds, maintenance and other occupancy costs. **Please Note:** If the amount reported in the total column for this account equals or exceeds 10% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes to Schedule A.

Note for DDD Providers only: *Day Services: Recognition of additional occupancy costs (Accounts 1510-1590) and Depreciation costs (Account 1710)*

An adjustment is necessary to transfer a portion of the occupancy costs within the Production center to Day Services. The process is as follows:

a. Determine the Percent of Norm for each consumer and the average of the total for all consumers being trained in a production area within the agency.
b. Multiply the Inverse Percent of Norm for all consumers (determined in "a" above) by the total occupancy costs for the Production center.

c. The amount of occupancy costs identified in "b" (above) is reduced from the Production occupancy costs and added to the Day Services occupancy costs.

1600 - EQUIPMENT

1600 - Purchase, Rental, Leases, Maintenance: The cost of equipment acquired with a per unit cost of less than $5,000, rental payments for equipment/vehicles used for the operation of the agency and costs associated with the repair or maintenance of agency equipment. *The threshold for capitalization of equipment was moved to $5,000 effective SFY08.*

1700 - DEPRECIATION

1710 - Building: Annual cost associated with the depreciation of agency office, program or residential facilities pursuant to American Hospital Association (AHA) Guidelines. *Direct assignment to benefiting service center based on square feet.*

1720 - Equipment: Item cost (if per unit cost greater than or equal to $5,000) associated with the depreciation of agency capital equipment and furnishings pursuant to AHA Guidelines. Examples include vehicles, computers, furniture, appliances and production equipment. *Note: The threshold for capitalization of equipment was moved to $5,000 effective SFY08.*

1800 - MISCELLANEOUS

1810 - Clothing: Cost of clothing purchased for consumers of the agency. *Report in the benefiting service center*

1860 - Bad Debt: Cost associated with non-collectable amounts. *Direct assignment to Adjustments Column for those costs associated with Program Services. Production bad debts should be reported under Production.*

1890 - Other: Miscellaneous costs such as those associated with personal needs, recreation and leisure, interest on installment contracts, and interest on operating loans. **Please Note:** If the amount reported in the total column for this account equals or exceeds 20% of the agency's total expenses, the agency must attach a breakdown of expenses by type and cost on the Notes to Schedule A.

Note: **Total Admin. & Support costs will be allocated based on total compensation costs. Schedule A is formulated to allocate the costs automatically. These cells are protected so that the formulas cannot be changed.**

TOTAL EXPENDITURES will be displayed automatically. These cells are protected; the formulas cannot be changed.

If the amount reported for Other expenses (accounts 1190, 1290, 1390, 1490, 1590 and 1890) equals or exceeds the percentage of the agency's total expenses (as indicated in the account description) the cell will be highlighted yellow to remind the agency to attach detail of expenses by type and cost.

If the amount reported on the "Total Personnel Services" line on Schedule A is greater than zero, the cell will be highlighted blue to remind the agency to allocate corresponding hours on Attachment One.

3. COST REPORT: SCHEDULE B – GROSS REVENUES

Columns and rows highlighted in gray (on the templates) are completed by DHS staff.

A. HORIZONTAL AXIS: TOTAL AND ADJUSTMENT COLUMNS/SERVICE CENTERS

The horizontal axis of Schedule B - Gross Revenues is comprised of the following:

Total - This column represents the total revenue for the reporting period from the operating statement of the organization. The total revenues must reconcile to the independently audited financial statements.

Adjustments - This column represents additions or deletions from the total column. Provide an explanation of any amounts reported in this column on the Notes to Schedule B.

Administration and Support - Revenue from administration and support services.

Fund Raising - Revenue from fund raising activities.

DSS Services - Revenue, regardless of funding source, used to fund…

DADA Program Services – Revenue, regardless of the funding source, used to fund all DADA services.

DMH Program Services – Revenue, regardless of the funding source, used to fund all DMH services.

DDD Program Services - Revenue, regardless of the funding source, used to fund services identified in Appendix A.

DRS Program Services - Revenue, regardless of the funding source, used to fund services identified in Appendix B.

Housing Services - Revenue from housing services. This should include the "room" portion of Room and Board. This service center may also include any amounts paid by the consumer (Client Pay) for Housing Services.

Food Services - Revenue from the delivery of food services. This should include the "board" portion of Room and Board. This service center may also include any amounts paid by the consumer (Client Pay) for Food Services.

Production - Revenue from production activities.

Other DHS Program Services - Revenue received for DHS Program Services other than those identified in the appendices as DDD Program Services or DRS Program Services. Examples include monies received for Family Support (DDD) programs. Provide an explanation of any amounts reported in this column on the Notes to Schedule B.

Non - DHS Program Services - Revenue received for services other than DHS Program Services. This includes services that do not appear in the appendices and that DHS does not participate in the cost, such as revenue received for Therapeutic Foster Care or 24/7 DUI program. Provide an explanation of any amounts reported in this column on the Notes to Schedule B.

B. VERTICAL AXIS - CHART OF ACCOUNTS

2000 - FEES
Dollars received for services provided to consumers.

2020 - Title XIX: Dollars received from DHS, for services provided to consumers within the scope of South Dakota's approved Title XIX State Plan/Waiver for consumers.

2045 - SD Department of Education: Dollars received for services provided to consumers under 21 years of age, when not participating with ICF/MR or HCBS.

2055 - Client Pay: Dollars received from clients as payment for services.

2060 - Insurance: Dollars received from insurance companies as payment for services.

2065 - Other States: Dollars received from other states for services provided to consumers.

2070 - Room and Board: Dollars received for room and board.

2075 - Bureau of Indian Affairs: Dollars received for services provided to Native American consumers, when not participating with ICF/MR or HCBS.

2080 – Department of Human Services: Dollars received from DHS contract funds.

2090 - Other: Dollars received from other sources (such as other Government Agencies/Departments and Local School District) as payment for services provided to consumers. An explanation of any dollars reported in this account should be included in the Notes to Schedule B.

2100 – GRANTS
Dollars received from City, County, State or Federal Government or other sources when expenses relating to a specific grant are incurred. Dollars received are for a specific consumer(s), position(s) or project(s). Dollars can also be received from other sources for services provided to clients.

2110 – Grants used for capital expenditures

2120 – Grants used for non-capital expenditures

2200 – CONTRIBUTIONS

Dollars donated or restricted for a specific service(s); report under the appropriate service(s). Documentation supporting the restriction must be available for review by Department staff.

2210 – Contributions used for capital expenditures 2220 – Contributions used for non-capital expenditures

2300 - OTHER INCOME

2310 - Commodities, Food Stamps, National School Lunch: The value of commodities and food stamps received and the amount of National School Lunch revenue.

2340 - FmHA Rent Subsidy: The amount of subsidy from FmHA.

2341 - Section 8 Assistance: The amount of Section 8 Assistance.

2350 - Transportation: Includes, but is not limited to, reimbursement from the Department of Social Services, Office of Adult Services and Aging.

2360 - Production: Revenue from production activities.

2370 - Investment Income/Interest: Investment Income/ Interest

2390 - Other: Dollars received from other sources for services provided to clients. An explanation of any dollars reported in this account should be included in the Notes to Schedule B.

Note: Revenues shall be directly assigned to the benefiting service/program column.

TOTAL REVENUES will be displayed automatically. These cells are protected; the formulas cannot be changed.

4. COST REPORT: SCHEDULE C- CENSUS DATA

Providers of Service for the Department of Social Services are required to complete and submit Schedule C. Census information must be provided by program and includes a count of all days when a client is physically present at the facility, leave days based on the distinction of being paid leave days or unpaid leave days and a column for any other types of days a facility may need to report. The facility information and program names will carry to the sheet from information provided on Schedule A.

Providers billing quarter hour units will report the number of units per month. The "paid leave", "unpaid leave" and "other" columns will not be applicable to providers billing quarter hour units and should be left blank.

Providers should indicate which method is used when reporting. Columns will be automatically totaled.

5. COST REPORT: SCHEDULE D – FTE SALARY SUMMARY

All providers shall complete the FTE Salary Summary entering the total salary amount in the Salary column and the number of FTEs in the FTE column for each position.. Columns will be automatically totaled.

6. COST REPORT ATTACHMENTS

A. ATTACHMENT ONE - STAFF

All providers shall prepare and submit Attachment One annually for all personnel for whom costs were reported in accounts 1010, 1020 and 1040 on Schedule A.

Columns highlighted in gray are completed by DHS staff.

Staff Credentials: Include education beyond high school and professional licenses or designations held. *For Example: BBA, CCDC II, QMHP, etc.*

Position Number: Assign a position number to each position in the agency. The position number will remain the same regardless of how many different individuals fill the position.

Example: Position #122 was filled by Mary Rose. Mary left the agency and Charlie Blue was hired to replace her. Charlie Blue's position number is #122.

A position cannot be occupied by more than one person at one time with the exception of overlap in occupancy due to training or there are part time staff filling one full time position. For example, if Mary Rose remained on duty for two weeks to train Charlie Blue, the position number would remain #122 for both Mary and Charlie.

Position numbers do not need to remain the same from year to year. For example, Mary Rose's position number may be #125 on the subsequent year cost report.

Position Title: Enter the title of each individual employee (i.e. Secretary, Residential Aid, Registered Nurse, etc.). A separate line should be used for each position.

Staff Name: Enter the name of each individual employee.

Start Date: Enter the date that the individual began employment with the agency. If the individual has been employed for more than a year, use the first day of the reporting period.

End Date: Enter the date the individual terminated employment with the agency. If the individual was still employed on the last day of the reporting period, enter the end date of the reporting period.

Total Hours Paid: Enter the total number of hours for which the employee was paid during the reporting period.

Note: When reporting 'on-call' hours, report only the hours actually worked while on call. For example, if the on-call person spent four hours responding to emergency calls, the four hours are reported in Total Hours Paid column and allocated to the appropriate service center. The total dollars paid are included in the Total Wages Paid column.

Salary: Enter the individual's gross salary for the reporting period. Only those employees who are paid a *salary* would be reported in this column. Hourly employees are reported in the **Hourly** column. Note: The gross salary should not include bonuses paid.

Hourly: Enter the employee's hourly wage. Use the hourly wage earned at the end of the reporting period.

Bonus: Enter bonuses paid. This includes bonuses, incentive payments, balloon/one-time payments, profit sharing, etc.

Total Wages Paid: Enter the total wages paid to the employee for hours worked during the reporting period. Do not include amounts reported in the **Bonus** column in the **Total Wages Paid** column.

# of Hours: Enter the number of hours the employee worked in each service center. The total of these columns will equal the amount in the **Total Hours Paid** and the **Total Hours** columns.

Total Hours: The sum of the hours reported in the **# of Hours** columns will be calculated automatically. This will equal the hours reported in the **Total Hours Paid** column.

If total hours paid under a specific service center on Attachment One are greater than zero, the cell will be highlighted blue to remind the agency to allocate corresponding expenses on Schedule A.

B. NOTES TO SCHEDULE A

Use this attachment to describe line item expenses.

a. Adjustment column items
b. Reconciliation between Audited Financial Statement and Schedule A
c. Breakdown of expenses by type and amount for those accounts exceeding the percentage limit
d. Any other notes you may want to provide

C. NOTES TO SCHEDULE B

Use this attachment to describe line item revenues.

a. Adjustment column items
b. Reconciliation between Audited Financial Statement and Schedule B
c. Breakdown of revenue by type and amount for other accounts (2090 and 2390)
d. Any other notes you may want to provide

7. APPENDICIES

APPENDIX A
Division of Mental Health Program Services (Horizontal Axis)

For all MH Program Services, activities such as orientation, staff training, personnel management, staff supervision, paperwork, and quality assurance are to be included in the cost of providing services. The cost report will accommodate the recording of these and other similar activities that are a necessary part of providing the following services:

Outpatient Services

90791 Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by someone who is not a Psychiatrist

90791 AM Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by a Psychiatrist

90791 SA Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by a Certified Nurse Practitioner or Physician Assistant

90832 Individual Psychotherapy: Individual therapy

90863 AM Pharmacologic Management: Psychiatric services for outpatient services

90863 SA Pharmacologic Management: Medication management provided by a Certified Nurse Practitioner or Physician Assistant

90846 Pharmacologic Management: Family therapy without the patient present

90847 Family Psychotherapy-With Patient Present: Family therapy with the patient present

90853 Group Psychotherapy (other than a multi-family group): Group therapy other than a multi-family group

99442 Telephone Evaluation and Management: Collateral Contacts

Comprehensive Assistance with Recovery and Empowerment (CARE) Services

H2016 HE Comprehensive Community Support Services: Serious Mental Illness (SMI) CARE

H2016 HE HW Comprehensive Community Support Services: SMI Transitional CARE

H0046 Mental Health Services, Non-Specified: Room and Board for CARE. This service code is reimbursed by state contract only.

H2016 HE TN Comprehensive Community Support Services Rural: SMI CARE Frontier (Rural) This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval.

90791 HE HB AM Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by a Psychiatrist for the CARE program

90791 HE HB SA Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by a Certified Nurse Practitioner or Physician Assistant for the CARE program

90863 HE HB AM Pharmacologic Management: Psychiatric services for the CARE program

90863 HE HB SA Pharmacologic Management: Medication management provided by a Certified Nurse Practitioner or Physician Assistant for the CARE program

Individualized and Mobile Program of Assertive Community Treatment (IMPACT)

H0039 HE Assertive Community Treatment, Face to Face: SMI IMPACT at Behavior Management Systems

H0039 HE HW Assertive Community Treatment, Face to Face: SMI IMPACT at Community Counseling Services

H0039 HE HT Assertive Community Treatment, Face to Face: SMI IMPACT at Southeastern Behavioral Health

H0039 HE SE Assertive Community Treatment, Face to Face: SMI IMPACT at Lewis and Clark Behavioral Health Services

H0039 HE HT SR Assertive Community Treatment, Face to Face: SMI IMPACT START (Plus) at Southeastern Behavioral Health; this service code is reimbursed by Medicaid only.

90791 HE HK AM Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by a Psychiatrist for the IMPACT program

90791 HE HK SA Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by a Certified Nurse Practitioner or Physician Assistant for the IMPACT program

90863 HE HK AM Pharmacologic Management: Psychiatric services for the IMPACT program

90863 HE HK SA Pharmacologic Management: Medication management provided by a Certified Nurse Practitioner or Physician Assistant for the IMPACT program

Children, Youth, and Family (CYF) Services

H2021 HE Community-Based Wrap-Around Services: SED individual regular

H2021 HE TN Community-Based Wrap-Around Services: SED individual frontier (rural); This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval.

H2021 HE HQ Community-Based Wrap-Around Services: SED group regular

H2021 HE HQ TN Community-Based Wrap-Around Services: SED group frontier (rural); This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval.

90791 HE HA AM Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by a Psychiatrist for SED

90791 HE HA SA Psychiatric Diagnostic Interview Exam: An evaluation, intake screening, and testing by a Certified Nurse Practitioner or Physician Assistant for SED

90863 HE HA AM Pharmacologic Management: Psychiatric services for SED

90863 HE HK SA Pharmacologic Management: Medication management provided by a Certified Nurse Practitioner or Physician Assistant for SED

Intensive Family Services (IFS)

H2021 HS TL Community-Based Wrap-Around Services: IFS regular; this service code is reimbursed by state contract only.

H2021 HS TL TN Community-Based Wrap-Around Services: IFS frontier (rural); This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. This service code is reimbursed by state contract only.

APPENDIX B

Division of Alcohol and Drug Abuse Program Services (Horizontal Axis)

For all ADA Program Services, activities such as orientation, staff training, personnel management, staff supervision, paperwork, and quality assurance are to be included in the cost of providing services. The cost report will accommodate the recording of these and other similar activities that are a necessary part of providing the following services:

Early Intervention Services and Counseling Codes: Level 0.5 or I.0 Services

H0001 Internal Assessments/Updates and Assessment/Updates - Adults: This service code is reimbursed with contract funds. Adolescents can be reimbursed with contract funds using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0001 HA Internal Assessments/Updates and Assessment/Updates – Adolescent: This service code is reimbursed by Medicaid/CHIPs. A unit of service is 15 minutes.

H0001 HD Internal Assessments/Updates and Assessment/Updates – Pregnant Women: The primary funding source for this code is Medicaid. A unit of service is 15 minutes.

Additional Information about H0001: Assessments:

1. Billable assessment time includes:
   a. The face to face interview with the client
   b. Collateral contacts made to obtain additional information or verification of assessment information
   c. Any additional face to face time spent with the client to make final recommendations.
2. All assessments must be contained in the client's clinical record before the agency bills the Division.
3. A new assessment is not required when a client moves from one level of care to another within the agency.
4. Collateral contact time/units for an assessment must be included in the H0001 service code and cannot be billed to T1007 Collateral Contacts/Referrals.
5. Units to be Reimbursed
   a. The Division will reimburse for a maximum of 32 units per fiscal year, per person for internal assessments, assessments or updates.
   b. The 32 unit maximum is a cumulative total of the time billed by all State contracted agencies per fiscal year.

H0004 Local Individual Counseling – Adults and Adolescents: This service code is reimbursed by state contract. Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0004 HA Local Individual Counseling – Adolescents: This service code is reimbursed by Medicaid/CHIPs. A unit of service is 15 minutes.

H0004 HD Local Individual Counseling – Pregnant Women: The primary funding source for

this service code is Medicaid. A unit of service is 15 minutes.

H0004 TN Rural Individual Counseling: This service code is reimbursed by state contract. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0004 HA TN Rural Individual Counseling – Adolescents: This service code is reimbursed by Medicaid/CHIPs. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. A unit of service is 15 minutes.

H0004 HD TN Rural Individual Counseling – Pregnant Women: The primary funding source for this code is Medicaid. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. A unit of service is 15 minutes.

H0005 Local Group Counseling – Adults and Adolescents: This service code is reimbursed by state contract. Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0005 HA Local Group Counseling – Adolescent: This service code is reimbursed by Medicaid. A unit of service is 15 minutes.

H0005 HD Local Group Counseling – Pregnant Women: The primary funding source for this code is Medicaid. A unit of service is 15 minutes.

H0005 TN Rural Group Counseling – Adults and Adolescents: This service code is reimbursed by state contract. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0005 HA TN Rural Group Counseling – Adolescent: This service code is reimbursed by Medicaid. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. A unit of service is 15 minutes.

H0005 HD TN Rural Group Counseling – Pregnant Women: The primary funding source for this code is Medicaid. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. A unit of service is 15 minutes.

H2011 Crisis Intervention Services - Adults: This service code is reimbursed with contract funds. Adolescents can be reimbursed with contract funds using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H2011 TN Crisis Intervention Services/Rural – Adults: This service code is reimbursed with contract funds and must be provided at least 20 miles, one way, from the accredited agency's

home station or with Division approval. Adolescents can be reimbursed with contract funds using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H2011 HA Crisis Intervention Services – Adolescent: This service code is reimbursed by Medicaid. A unit of service is 15 minutes.

H2011 HA TN Crisis Intervention Services/Rural – Adolescent: This service code is reimbursed by Medicaid and must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. A unit of service is 15 minutes.

H2011 HD Crisis Intervention Services - Pregnant Women: The primary funding source for this code is Medicaid. A unit of service is 15 minutes.

H2011 HD TN Crisis Intervention Services/Rural - Pregnant Women: The primary funding source for this code is Medicaid and must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. A unit of service is 15 minutes.

Additional Information about H2011: Crisis Intervention Services:

1. A limit of 8 units (2 hours) is permitted for each crisis situation per person, per day, with an annual limit of 24 units (6 hours).
2. The 24 unit maximum is a cumulative total of the time billed by all State contracted providers per 12 month period.
3. Crisis Intervention billable units include both face to face and over the phone contacts.
4. Crisis Intervention services are not to be billed after a client is entered into an ASAM level of care.

H2022 Early Intervention Services: The Division will reimburse a maximum of 192 units (48 hours) per year per client for alcohol and drug intervention services. A unit of service is 15 minutes.

T1006 Local Family/Couple Counseling: This category is reimbursed by state contract. A unit of service is 15 minutes.

T1006 TN Rural Family/Couple Counseling: This category is reimbursed by state contract. Rural services must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. A unit of service is 15 minutes.

T1007 Collateral Contacts/Referral: This service code is limited to non-gambling clients. This service requires an ASAM Level Admission Record in STARS. Agencies may combine multiple collateral contacts, which are less than 15 minutes in length, made on behalf of a single client and submit for billing. Collateral communications may be in person, over the phone or electronic communication and must be documented in the client's record. A unit of service is 15 minutes.

T1013 Sign Language or Oral Interpretive Services: This service code is reimbursed with contract funds. Cost for local travel is included in the fee rate. A unit of service is 15 minutes.

Intensive Outpatient Services Codes: Level II.1 and II.5

H0015 Intensive Outpatient Treatment – Group/Family: This service code is reimbursed by state contract. Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0015 HE Intensive Outpatient Treatment – Individual: This service code is reimbursed by state contract. Agencies are limited to billing 3 hours per week. Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0015 HD Intensive Outpatient Treatment for Pregnant Women – Group/Family: Clients being billed in this category must be pregnant. Medicaid is the primary funding source for this service code. A unit of service is 15 minutes.

H0015 HD HE Intensive Outpatient Treatment for Pregnant Women – Individual: Agencies are limited to billing 3 hours per week. Pregnant women and/or women with dependent children can be reimbursed with contract funds using this code if the client is denied Medicaid and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0015 HA Intensive Outpatient Treatment for Adolescents – Group/Family: This service code is reimbursed by Medicaid/CHIPs. A unit of service is 15 minutes.

H0015 HA HE Intensive Outpatient Treatment for Adolescents – Individual: This service code is reimbursed by Medicaid/CHIPs. Agencies are limited to billing 3 hours per week. A unit of service is 15 minutes.

H0015 HA HD Pregnant Adolescent Intensive Outpatient Treatment – Group/Family: Clients being billed to this category must be pregnant. This service code is reimbursed by Medicaid/CHIPs. A unit of service is 15 minutes.

H0015 HA HD HE Intensive Outpatient Treatment Pregnant Adolescent-Individual: Agencies are limited to billing 3 hours per week. Clients being billed to this category must be pregnant. This service code is reimbursed by Medicaid/CHIPs. A unit of service is 15 minutes.

H0015 TN Rural Intensive Outpatient Treatment – Group/Family: This service code is reimbursed by state contract. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is 15 minutes.

H0015 HE TN Rural Intensive Outpatient Treatment – Individual: This service code is reimbursed by state contract. Agencies are limited to billing 3 hours per week. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract

Preamble. A unit of service is 15 minutes.

H0015 HD TN Rural Intensive Outpatient Treatment for Pregnant Women – Group/Family: Clients meeting this category must be pregnant. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. Medicaid is the primary funding source for this service code. A unit of service is 15 minutes.

H0015 HD HE TN Rural Intensive Outpatient Treatment for Pregnant Women – Individual: Agencies are limited to billing 3 hours per week. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. Medicaid is the primary funding source for this service code. A unit of service is 15 minutes.

H0015 HA TN Rural Intensive Outpatient Treatment for Adolescents – Group/Family: This service code is reimbursed by Medicaid/CHIPs. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. A unit of service is 15 minutes.

H0015 HA HE TN Rural Intensive Outpatient Treatment for Adolescents – Individual: Agencies are limited to billing 3 hours per week. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. This service code is reimbursed by Medicaid/CHIPs. A unit of service is 15 minutes.

H0015 HA HD TN Rural Pregnant Adolescent Intensive Outpatient Treatment – Group/Family: Clients being billed to this category must be pregnant. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. This service code is reimbursed by Medicaid/CHIPs. A unit of service is 15 minutes.

H0015 HA HD HE TN Rural Pregnant Adolescent Intensive Outpatient Treatment – Individual: Agencies are limited to billing 3 hours per week. This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. This service code is reimbursed by Medicaid/CHIPs. A unit of service is 15 minutes.

H2036 Intensive Day Treatment – Adults and Adolescents: Adolescents can be billed using this code if the client is denied Medicaid/CHIPs and completes the financial eligibility documentation referred to in the Contract Preamble. A unit of service is one day.

H2036 HA Intensive Day Treatment for Adolescents: This service code is reimbursed by Medicaid/CHIPs, and prior authorization by the Division is required. Services for adolescents attending day treatment funded by Medicaid/CHIPs may not include Room and Board. A unit of service is one day.

H2036 HA HD Intensive Day Treatment for Pregnant Adolescents: Adolescents must be pregnant. This service code is reimbursed by Medicaid/CHIPs, and prior authorization by the Division is required. Services for adolescents attending day treatment funded by Medicaid/CHIPs may not include Room and Board. A unit of service is one day.

Clinically Managed Low Intensity Residential Services: Level III.1

A unit of service is one day for Clinically Managed Low Intensity Residential Services.

H0016 Clinically Managed Low Intensity Residential - Adult: This service code is reimbursed by state contract.

H0016 HA Clinically Managed Low Intensity Residential - Adolescents: This service code is reimbursed by Medicaid/CHIPs, and prior authorization by the Division is required.

H0016 HD Clinically Managed Low Intensity Residential - Pregnant Women and/or Women w/ Dependent Children: Clients must be pregnant substance abusing women and/or substance abusing women with children. This service code is reimbursed by state contract, and prior authorization from the Division is required.

H0016 HA HD Clinically Managed Low Intensity Residential - Pregnant Adolescents and/or Adolescents w/ Dependent Children: Clients must be pregnant substance abusing adolescents and/or substance abusing adolescents with children. This service code is reimbursed by Medicaid/CHIPs, and prior authorization by the Division is required.

II.1/III.1 (formerly Slip/Slot) Services (Level II.1: Intensive Outpatient Treatment and III.1: Low Intensity Residential Services).

The following codes may be billed together when a client is in Level II.1/III.1 Services.

H0015 HF Intensive Outpatient Treatment (II.1/III.1 (formerly Slip/Slot)) Adult -- Group/Family: This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0015 HE HF Intensive Outpatient Treatment (II.1/III.1 (formerly Slip/Slot)) Adult-Individual: This services code is reimbursed by state contract. Agencies are limited to billing 3 hours per week. A unit of service is 15 minutes.

H0016 HF Clinically Managed Low Intensity Residential (II.1/III.1 (formerly Slip/Slot)) Adult: This service code is reimbursed by state contract. A unit of service is one day.

Intensive Inpatient (Residential) Treatment: Level III.7

A unit of service is one day for Intensive Inpatient Treatment.

H0019 Adult Medically Monitored Intensive Inpatient Treatment Program: This service code is reimbursed by state contract, and prior authorization from the Division is required.

H0019 HA Adolescent Psychiatric Residential Treatment Facility: This service code is reimbursed by Medicaid/CHIPs, and prior authorization from the Division is required.

H0019 HD Medically Monitored Intensive Inpatient Treatment for Pregnant Women and/or Women w/ Dependent Children: Clients must be pregnant substance abusing women and/or substance abusing women with children. This service code is reimbursed by state contract or Medicaid, and prior authorization from the Division is required.

H0019 HA HD Psychiatric Residential Treatment Facility – Pregnant Adolescents: Clients must be pregnant. This service code is reimbursed by Medicaid/CHIPs, and prior authorization from the Division is required.

H0018 HA Psychiatric Residential Treatment Facility – Short Term Relapse Program: This service code is reimbursed by Medicaid/CHIPs, and prior authorization from the Division is required.

Clinically Managed Residential Detoxification: Level III.2-D

H0014 Clinically Managed Residential Detoxification: An initial assessment and all counseling services (individual, group, and family counseling) are included in the detoxification program and are not billed separately while an individual is in residential detoxification. A unit of service is 12 hours (one half day).

Recovery Support Services

H2015 Recovery Support Services: Billable contacts include both face to face and over the phone. This service is limited to a total of 192 units (48 hours) of contact over the first year subsequent to the initial contact for each client. Initial contact can be either the first pre-treatment contact or actual treatment contact. This service code is reimbursed by state contract. A unit of service is 15 minutes.

Gambling Treatment

In order to bill for gambling services, gambling does not have to be the primary diagnosis. If a gambling problem is discovered during the course of treatment, this information should be added to the client's admission screen in STARS prior to submitting claims utilizing the appropriate code listed below.

H0001 HV Gambling -- Assessment/Updates: This service code can be utilized for all Gambling Assessments/Updates for State Contract and Non-Contract reporting. This service code is reimbursed by state contract. A unit of service is 15 minutes.

1. The time used for determining the units should include the face to face interview with the client, collateral contacts made to obtain additional information or verification of assessment information.
2. Collateral contact time/units for an assessment should be included in the H0001 HV service code.

H0004 HV Gambling – Local Individual Counseling: This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0004 HV TN Gambling – Local Individual Counseling/Rural: This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0005 HV Gambling -- Local Group Counseling: This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0005 HV TN Gambling -- Local Group Counseling/Rural: This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0015 HV Gambling -- Intensive Outpatient Treatment –Group/Family: This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0015 HE HV Gambling -- Intensive Outpatient Treatment – Individual: Agencies are limited to billing 3 hours per week. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H2011 HV Gambling -- Crisis Intervention Service: This service, either via phone or face to face, applies to intervention services provided to an individual experiencing a crisis situation related to his/her gambling. This service code is reimbursed by state contract. A unit of service is 15 minutes.

1. A limit of 8 units (2 hours) is permitted for each crisis situation per person, per day, with an annual limit of 24 units (6 hours).
2. Neither an admission record in STARS nor the completion of a Means 101 form is required for reimbursement.
3. Once the client is admitted into gambling treatment, individual crisis situations need to be billed toward the appropriate level of care service code.

H2011 HV Gambling -- Crisis Intervention Service/Rural: This service must be provided at least 20 miles, one way, from the accredited agency's home station or with Division approval. This service is reimbursed by state contract. A unit of service is 15 minutes.

H2036 HV Gambling - Day Treatment: This service code is reimbursed by state contract. A unit of service is one day.

H0019 HV Gambling - Intensive Inpatient Treatment: Prior authorization from the Division and Means testing is required. This service code is reimbursed by state contract. A unit of service is one day.

Keystone Methamphetamine Program

The following billing codes are used for clients in the Keystone Meth Program. Phase 1: Detoxification and Phase 2: Inpatient services can be billed for a combined total of 30 days.

H0014 HB HG Medically Managed Residential Detoxification (Phase 1): The service code is reimbursed by state contract. Any medications directly related to the client's meth use are included in the rate of reimbursement. A unit of service is 12 hours.

H0019 HB HG Medically Monitored Intensive Inpatient Treatment (Phase 2): This service code is reimbursed by state contract. A unit of service is one day.

Phase 3:
H0015 HB HF HG Intensive Outpatient Treatment (II.1/III.1 (formerly Slip/Slot)) – Group/Family: Intensive Outpatient Treatment (II.1/III.1 (formerly Slip/Slot)) is provided by Keystone. This service code is reimbursed by state contract. Clients receiving services under

this code may also be billed by another contracted agency under H0016 HB HF HG for Residential Services. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0015 HB HE HF HG Intensive Outpatient Treatment (II.1/III.1 (formerly Slip/Slot)) – Individual: Agencies are limited to billing 3 hours per week of Individual Intensive Outpatient Treatment. Intensive Outpatient Treatment (II.1/III.1 (formerly Slip/Slot)) is provided by Keystone. This service code is reimbursed by state contract. Clients receiving services under this code may also be billed by another contracted agency under H0016 HB HF HG for Residential Services. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0016 HB HF HG Low Intensity Residential (II.1/III.1 (formerly Slip/Slot)): The Low Intensity Residential portion of II.1/III.1 (formerly Slip/Slot) services is provided by another contracted agency outside of Keystone. This service is reimbursed by state contract. Clients who attend this program are also receiving services in the Intensive Outpatient Treatment program at Keystone. A unit of service is one day.

H0015 HB HG Intensive Outpatient Treatment – Group Family Intensive Outpatient Treatment is provided by Keystone. This service code is reimbursed by state contract. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0015 HB HE HG Intensive Outpatient Treatment – Individual: Agencies are limited to billing 3 hours per week of Individual Intensive Outpatient Treatment provided by Keystone. This service code is reimbursed by state contract. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0016 HB HG Low Intensity Residential: Upon completion of the Intensive Outpatient portion of II.1/III.1 (formerly Slip/Slot) services, this service code can be billed until transferred to Aftercare- Counseling Services. Low Intensity Residential, including any Low Intensity Residential II.1/III.1 (formerly Slip/Slot) Services, can only be billed for 90 days. A unit of service is one day.

Phase 4:

H0004 HB HG Aftercare – Local Individual Counseling: The client is responsible for payment during this Phase; however, it is the agency's discretion to make an exception for a client and bill state contract. Clients must meet the income eligibility guidelines if state contract is billed. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0005 HB HG Aftercare – Local Group Counseling: The client is responsible for payment during this Phase; however, it is the agency's discretion to make an exception for a client and bill state contract. Clients must meet the income eligibility guidelines if state contract is billed. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H2015 HB HG Comprehensive Community Support Services: This service code may be reimbursed by state contract while the client participates in Intensive Outpatient Treatment with or without II.1/III.1 (formerly Slip/Slot) services and during Aftercare. This service code is reimbursed by state contract. A unit of service is 15 minutes.

City/County Alcohol and Drug Methamphetamine Program

The following billing codes are used for clients in the City/County Meth Program.

H0014 EY HB HG Clinically Managed Social Detoxification (Phase 1): Any medications directly related to the client's meth use are included in the rate of reimbursement. This service code is reimbursed by state contract. A unit of service is 12 hours.

H2036 HB HG Intensive Day Treatment (Phase 2): This service code is reimbursed by state contract. A unit of service is one day.

H0015 HB HG Intensive Outpatient Treatment – Group/Family: This service is reimbursed by state contract. This code may also be used during Pre-Treatment. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0015 HB HE HG Intensive Outpatient Treatment – Individual: Agencies are limited to billing 3 hours per week. This service is reimbursed by state contract. This code may also be used during Pre-Treatment. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0015 HB HF HG Intensive Outpatient Treatment (II.1/III.1 (formerly Slip/Slot)) – Group/Family: Clients who attend this program are also receiving Low Intensity Residential Services. This service is reimbursed by state contract. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0015 HB HE HF HG Intensive Outpatient Treatment (II.1/III.1 (formerly Slip/Slot)) – Individual: Agencies are limited to billing 3 hours per week. Clients who attend this program are also receiving Low Intensity Residential Services. This service is reimbursed by state contract. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0016 HB HF HG Low Intensity Residential Treatment (II.1/III.1 (formerly Slip/Slot)): Clients who attend this program are also receiving services in the intensive outpatient treatment program with special emphasis on relapse prevention planning. All requirements of II.1/III.1 (formerly Slip/Slot) programming must be fulfilled. This service is reimbursed by state contract. This service code is reimbursed by state contract. A unit of service is one day.

H0016 HB HG Low Intensity Residential Treatment (Phase 4a): All requirements of Low Intensity Residential Treatment programming must be fulfilled. This service is reimbursed by state contract. This service code is reimbursed by state contract. A unit of service is one day.

H0004 HB HG Aftercare – Local Individual Counseling (Phase 4b): The client is responsible for payment during this Phase; however, it is the agency's discretion to make an exception for a client and bill state contract. Clients must meet the income eligibility guidelines if state contract is billed. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0005 HB HG Aftercare – Local Group Counseling (Phase 4b): The client is responsible for payment during this Phase; however, it is the agency's discretion to make an exception for a

client and bill state contract. Clients must meet the income eligibility guidelines if state contract is billed. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H2015 HB HG Comprehensive Community Support Services: This service code may be reimbursed by state contract while the client participates in Intensive Outpatient Treatment with or without II.1/III.1 (formerly Slip/Slot) services and during Aftercare. This service code is reimbursed by state contract. A unit of service is 15 minutes.

South Dakota Women's Prison Intensive Methamphetamine Treatment Program

Phases 1 and 2 are completed within the South Dakota Women's Prison. Contracted community agencies provide Phases 3 and 4 using the codes below. These service codes are to be used **only** for women involved in the Intensive Methamphetamine Treatment Program through the Solem Public Safety Center (Women's Prison).

H0016 HG Clinically Managed Low Intensity Residential Intensive Meth Treatment (IMT Women) Phase 3: Agencies are not allowed to charge the client above the Division's reimbursement rate for this level of care. A unit of service is one day.

H0004 HG Local Individual Counseling for the Intensive Methamphetamine Treatment Program (IMT Women) Phase 4: This service code is reimbursed by state contract for the first 90 days a client is in Phase 4. After the first 90 days, the client is responsible for payment. This service code is reimbursed by state contract. A unit of service is 15 minutes.

H0005 HG Local Group Counseling for the Intensive Methamphetamine Treatment Program (IMT Women) Phase 4: This service code is reimbursed by state contract for the first 90 days a client is in Phase 4. After the first 90 days, the client is responsible for payment. This service code is reimbursed by state contract. A unit of service is 15 minutes.

APPENDIX C

Division of Developmental Disabilities Program Services (Horizontal Axis)

For all DD Program Services, activities such as orientation, staff training, personnel management, staff supervision, paperwork, and quality assurance are to be included in the cost of providing services. The cost report will accommodate the recording of these and other similar activities that are a necessary part of providing the following services.

Service Coordination - Services to assist individuals to gain access to needed medical, habilitative, social, and other related services and supports such as guardianship, legal, self-advocacy, housing, follow-up/outreach, referral or financial/payee assistance. In order to be considered service coordination, these services must be provided by the staff responsible for overall service coordination of an individual's plan. Salaries and benefits for staff such as service coordination aides and secretaries should also be included in this service center.

Residential Services - Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings, including but not limited to, acquisition, retention, or improvement in skills related to activities of daily living.

Residential services may be provided in the following settings

1. "Specialized Family Homes" are adult foster homes licensed by the Department of Health, or children's foster homes licensed by the Department of Social Services.
2. "Family homes", i.e., living "with parents, relatives or guardian."
3. Supported Living Level 1: People need and receive services and supports from staff 24 hours daily.
4. Supported Living Level 2: People need and receive services and supports from staff during all waking hours.
5. Supported Living Level 3: All other residential services.

Home Size

1. In foster care settings, home size is determined by the number of people for whom residential services are provided within a home.
2. In family homes, home size is determined by the number of people for whom residential services are provided within a home.
3 In Level 1 - 2, home size is established by the number of people supported by the agency who are residing at that address. This number is established on an annual basis and is subject to change through the significant change process.
4. In Level 3, home size is established by the number of people supported by the agency living in an apartment or house.

Day Services - Day habilitation services provide assistance with acquisition, retention or improvement in self-help, socialization, adaptive and safety skills, compliance, attending to task and task completion, and problem-solving, communication skills, gross and fine motor skills, and the reduction of maladaptive behavior, which takes place in a residential or a non-residential setting. Day habilitation services are not limited to fixed-site facilities.

Day habilitation services shall focus on enabling the participant to attain or maintain their maximum functional level and shall be coordinated with any physical, occupational or speech therapies listed in the plan of care. In addition, day habilitation services may be taught to reinforce skills or lessons taught in school, therapy or other settings.

Day habilitation services may be provided in day activity, work activity or sheltered workshop settings operated by the CHOICES provider. Day habilitation services may be provided in community settings to improve or maintain a participant's skills in communication, socialization, mobility, health and physical fitness, leisure and retirement and educational and functional skills.

Day Habilitation services do not include production of goods or services, nor compensation for participants that is consequential. Transportation between the participant's place of residence and the day habilitation site is provided as a component of Day Habilitation services and the cost of this transportation is included in this rate.

Day Hours
Day hours are the total of all day activity, work activity, sheltered workshop "hours per week" and Non Paid Activities ("Non Paid Hours per Week") from the Day Hours screen in the Service Record. The number of hours a person receives day services is determined by the hours of staff supervision provided, including transportation time. This includes **all** alternative service hours and transportation hours. Rule of thumb - Any staff supervised hours during the day that do **not** include residential activities such as bathing, laundry, cleaning residential areas and cooking.*

Pre-Vocational Services - Pre-vocational services primary focus is preparing a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem-solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the participant's ISP and are directed to habilitative rather than explicit employment objectives and may include enclaves and work crews. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 100 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Pre-Vocational Hours
The number of hours a person receives pre-vocational services is determined by the hours of staff supervision provided, including transportation time. Rule of thumb – Any staff supervised hours during the day that prepares a participant for paid or unpaid employment.

Note: Begin tracking Pre-Vocational services/hours for FY09

Supported Employment Services - Paid employment for people who need intensive ongoing support to perform in a work setting, and are not yet able to be competitively employed at or above minimum wage. Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. Supported employment services are directed towards assisting individuals to retain paid employment in a community setting. These services include job finding and job placement activities.

Supported Employment Services Hours
The number of hours a person receives supported employment services is determined by the hours of staff supervision while at work. Supported Employment hours is the total number of "hours per week" identified on the Supported Employment Screen in the Service Record, and includes **only** independent job placements.*

**Sum Day Habilitation, Pre-Vocational Hours and Supported Employment Hours for total Daytime Hours. The total may NOT exceed 80 hours.*

Nursing Services - Medical services provided by a registered nurse or licensed practical nurse (in accordance with state law) which include screenings and assessments, nursing diagnosis, treatment, staff training, monitoring of medical care and related services, policy and procedure development and review, and response to medical emergencies. Also includes staff activities such as tuberculin tests, phlebotomy for hepatitis screenings, etc. Salary and benefits for staff such as nursing aides and nursing secretaries should also be included in this service center.

Medical Services: For Speech, Hearing & Language, Medical Equipment & Drugs, and Other Medical Services expenditures, report those expenditures on the cost report that are not directly covered by the Medicaid State Plan. Costs associated with these services that are incurred by the agency (regardless of if the service is reported on the service record) should be reported as expenses on the agency's cost report.

Speech, Hearing, & Language Services - Services provided by qualified professionals including evaluation, program design, direct services, staff training, and policy and procedure review. Communication programs and related services to improve general socialization skills would not be included, unless they are developed to reduce or eliminate certain undesired effects of a specific speech/language or hearing disorder.

Medical Equipment & Drugs - Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design, and installation. Also includes drugs, chemicals, or preparations for the prevention, relief, or cure of diseases, including prescribed nutritional supplements, which are not available under the state plan.

Other Medical Services - Direct therapies, treatment and services which are limited to those not available under the state plan, and are provided by physicians, physicians' assistants, speech, physical and occupational therapists, pharmacists, optometrists, chiropractors, and dietitians. Services, therapies, and treatments provided directly to the individual are indicated in the individual's plan of care. Services will be furnished in an outpatient setting, and will ensure the optimal functioning of the individual. Consultations by a dietitian on agency menus rather than on a specific dietary plan for a specific individual should be allocated to Food Service rather than this Service Center.

Transportation between the individual's place of residence and other medical services will be provided as a component part of these services unless covered by the Medicaid State Plan. The cost of this transportation is included in the rate paid for other medically-related services.

Housing Services - Buildings, furnishings, supplies, utilities, local telephone service, depreciation, interest, and maintenance costs to provide housing for individuals needing such services.

Note: A unit of housing is defined as having a bed available/reserved for a specified consumer, regardless of whether they occupy it every night (not capacity).

Food Services - Food, related dietary items, equipment (including major appliances for cooking and storing food), materials for preparation, serving, and storage, and staff or dietary consultant costs associated with the delivery of food services which are needed to meet the specified nutritional needs of individuals receiving services.

Note: A unit of meal service is defined as an actual meal served to a consumer.

Production - Enterprises related to producing marketable goods or services for sale by the agency or another organization under a sub-contract agreement. Expenses associated with marketing, product development, labor, materials, quality control, and sales are reported under this service center.

APPENDIX D
Division of Rehabilitation Services (Horizontal Axis)

INDEPENDENT LIVING SERVICES

Independent Living Services no longer need to be reported under separate service centers. One reimbursement rate has been established for all Independent Living Services; therefore, all services listed below can be reported on the Cost Report under one service center.

Information and Referral Services - Services provided in relation to an individual's rights, resources, and responsibilities. These services offer individuals information on a wide range of disability-related topics. Services to assist an individual to obtain adaptive modifications that address the barriers confronted by individuals with significant disabilities with respect to education, rehabilitation, employment, and transportation.

Independent Skills Training - Training to assist individuals to make the most of their abilities and to increase self-reliance and self-confidence. This is done by teaching individuals how to take control of their lives. Skills can be taught at the center, in a classroom or workshop setting, or in the community. In some cases, skills training is provided in the individual home to help and individual learn new tasks in a familiar setting. This section should not include teaching an individual to use an adaptive device such as an emergency dialer, reacher, nail clippers or shower chair as the primary independent living goal. These can be secondary goals.

Peer Counseling – A peer counselor helps to promote personal growth by sharing their own experiences and explaining how they have coped with the "ups and downs" of having a disability. These services may also include information sharing, psychological services of non-psychiatric, non-therapeutic nature and parent to parent opportunities.

Individual and Systems Advocacy - These services assist an individual in developing the skills needed to advocate on their own behalf within the independent living services process and in all activities of daily living. Includes community awareness programs to enhance the understanding and integration into society of individuals with disabilities.

Children's Services - These services are available for children under the age of 14 to supplement services already offered by the school system to foster the child's learning and ability to function independently.

Housing - Services related to securing housing and shelter.

Mobility Training - A variety of services involving assisting an individual to get around their home and community.

Personal Assistance Services - These include, but are not limited to, assistance with personal bodily functions, communicative, household, mobility, work, emotional, cognitive,

personal, and financial affairs, community participation, parenting, leisure, and other related needs.

Physical Rehabilitation (restoration) Services - Restoration services to include medical services, health maintenance, eyeglasses and visual services.

Preventative Services - Services intended to prevent additional disabilities, or to prevent an increase in the severity of an existing disability.

Prostheses and Other Appliances - Services that provide or assist in obtaining an adaptive device or appliance to substitute for one or more parts of the body.

Recreational Services - Services that assist the consumer to identify opportunities in the community that provide meaningful leisure time activities.

Transportation Services - Services that assist an individual to secure reliable and safe transportation.

Youth Transition Services - Services for youth 14-24 that promote self-awareness, self-esteem, advocacy and self-empowerment skills. Assists an individual to explore career options, including transition from school to post school activities such as post-secondary education, vocational training, employment, education, adult services, independent living or community participation.

Home Modifications and Assistive Devices (HMAD) - Devices and modifications that assist and teach a consumer to function independently in the family or community or to obtain, maintain, or advance in employment.

Technology Adaptive Devices (TAD) - Devices that assist a consumer to independently communicate or to answer the phone.

Community Support Services

Community Support Services no longer need to be reported under separate service centers. One reimbursement rate has been established for all Community Support Services; therefore, all services listed below can be reported on the Cost Report under one service center.

Information and Referral – Services provided in relation to a consumers rights or referral to other resources. Information and referral can assist the consumer to obtain services through other sources on wide range of disability-related topics, or information and referral that address the barriers confronted by individuals with deafness with respect to education, rehabilitation, employment, and transportation.

Peer Support – Services to promote personal growth by sharing their own experiences and explaining how they have coped with and adjusted to having a hearing loss. These services may also include information sharing, support services, mentoring and parent to parent

opportunities. Could include informal support groups for hard of hearing persons to share experience and seek guidance in coping with their hearing loss. Peer Support may help facilitate personal and social adjustment skills, communication skills, educational activities, and develop resources.

Individual Advocacy – These services assist an individual in developing the skills needed to advocate on their own. Community awareness programs to enhance the understanding and integration into society of individuals with hearing loss.

Communication Assistance - Sign language classes to help parent and caregivers to communicate more effectively with deaf individuals and to help in bridging the communication and cultural gap.

Community Integration Skills Training – Individualized teaching, mentoring, and guidance services that enable consumers to access services in the community. Planned services can include national supports, social supports, skill development, and communication supports that will enhance the consumer's ability to be more independent.

Travel – Cost can be billed when travel is needed to provide services through EDP distribution or other services as needed.

Deaf Awareness Presentations/ Training – Trainings on different aspects that are related to deafness to help in bridging the communication and cultural barriers associated with deafness between three communities: deaf, hard of hearing, and hearing.

Technical Assistance/ Consultation – Technical assistance or consultative services provided to Centers of Independent Living, Schools, VR, Medical, Parents, Employers, and Businesses to enhance the consumer's experience.

Appendix E

Supplemental Information

THINGS TO REMEMBER

General

- Some cells have been protected (you will not be able to click in the cell) so that changes cannot be made to the formulas. Some cells will automatically calculate and be displayed. The cells in gray are protected; you do not have to complete them.
- Schedules A and B, Notes to Schedules A and B, and Attachment One have been combined into one workbook.
- Please use the following naming conventions when submitting the files: **AgencyName_Schedules and Attachments.xls.** *AgencyName* should be the full or abbreviated name of your agency.
  Example: SDA_Schedules and Attachments.xls (Behavior Management Systems)
- DDD and DRS cost reports should be emailed to Jessicca Bardeson at jessicca.bardeson@state.sd.us
- DADA and DMH cost reports should be emailed to Greg Evans at greg.evans@state.sd.us

Attachment One and Schedule A

- If personnel expenses are reported on Schedule A for a specific service center, Attachment One should include corresponding hours for employees that work in the same service center.
- If Attachment One includes hours for employees for a specific service center, Schedule A should have corresponding expenses in the same service center.
- For agencies providing more than one type of program services (i.e. DDD and DRS), the costs associated with the staffing hours reported in the Admin columns on Attachment One will be combined in the Admin & Support column on Schedule A.
- Personnel hours (unless the staff are contracted, consumers or temporary) should be reported for all services an agency is contracted by DHS or DSS to provide.

Attachment One

- Staff credentials need to be included. They should include education beyond high school and licenses or designations held. For example: BBA, CCDC II, QMHP, etc.
- Start/End dates need to be included. If an individual was employed with the agency prior to the start of the reporting period, use the start date of the reporting period. If the individual is still employed with the agency at the end of the reporting period, use the end date of the reporting period.
- The Total Hours Paid column should equal the Total Hours per Employee column.
- A position number should be assigned to each position at the agency. A position cannot be occupied by more than one person at one time with the exception of overlap in occupancy due to training. Position numbers do not need to be the same for each employee from year to year.
- Employees spending more than 10% of their time providing direct service should be listed on the 1020 tab.

- As much as possible, hours for all employees (including support employees such as maintenance and custodial staff) need to be allocated to the benefiting service center.

- Contract employees and temporary staff are not included on Attachment One. Expenses do need to be recorded on Schedule A; line 1200 for contract employees and 1060 for temporary staff.

Schedule A

- If personnel costs are listed for a specific service center, benefits and taxes should be allocated to the benefiting service center.
- All expenses, if possible, need to be allocated directly to the benefiting service center. This includes personnel, occupancy, supply and any other expenses that can be directly allocated.
- Bad debt and other unallowable costs should be reported in the adjustments column. Refer to pages 8 and 9 of the guidelines for a list of unallowable costs.

Schedule B

- Contract funds received from the Department of Human Services should be included in the 2080 account. They should also be identified on the Notes to Schedule B.
- Revenue should be identified in the column corresponding to the Program Services for which funds were received.
- If expenses are reported under the "Other" column on Schedule A, there should be corresponding revenue reported under the "Other" column on Schedule B.

FREQUENTLY ASKED QUESTIONS

General

Q: What is the submission deadline for the cost reports and audits?

A: The cost report and audit are due four months following the end of your agency's fiscal year. If your fiscal year ends June 30th, the cost report and audit are due November 1st. If your fiscal year ends December 31st, the cost report and audit are due May 1st. Once the cost report is submitted to the department, department staff will review for accuracy. If the department has any questions or discovers any inaccuracies related to the cost report, the provider has 30 days from the department's initial inquiry to submit a completed cost report.

Q: Are the cost report components required to be filed annually? Section 1.B.1

A: Yes, the cost report components became part of the annual audit in FY04.

Q: How is the cost report and audit information to be submitted? Section 1.B.2

A: Schedule A and Schedule B, along with the Notes to Schedule A and Schedule B, must be included as part of the annual entity wide audit provided as a paper copy to the Department of Social Services as prescribed in Section 2, 3 and 4 of the Cost Report Guidelines. Schedules A and B and Attachment One shall be uploaded to the SD MEDX system. Upon successful upload, department staff will review the report.

Q: Where do I find the cost report templates?

A: The cost report templates are updated annually and posted on the Provider Reimbursements and Audits webpage on the Department of Social Services website. The site can be found at **http://dss.sd.gov/financeoffice/reimbursementaudits/index.asp**. You can also contact the Office of Provider Reimbursements and Audits at the Department of Social Services at (605) 773-3643.

Schedule A - Expenses

Q: What is the CMS Pub 15 that is identified in the Unallowable Costs section of the Cost Report Guidelines? Section 1.C.9

A: The CMS Pub. 15 is the Centers for Medicare and Medicaid Services (now CMS and formerly HCFA) Provider Reimbursement Manual (PRM). This includes instructions on calculating Medicare payments to hospitals and skilled nursing facilities that are reimbursed under the prospective payment system, as well as other providers that are reimbursed on a reasonable cost basis. The CMS Pub. 15 can be found at the CMS website http:http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html

Q: Can all building depreciation expenses fall under Administration since administrative costs get spread to all centers? Section 2.B (under 1700-Depreciation)

A: The correct allocation is based on square footage assigned to the service center.

Q: Do we subtract client wages from the total personnel expenditures when calculating the testing threshold of 65%? Section 1.C.4

A: Client wages should not be subtracted from total expenditures when calculating the testing threshold.

Schedule B - Revenues

Q: Where do we record income from a source other than DHS? Section 3.A

A: You need to determine what the revenue was used for. For example, if Developmental Disabilities Services as identified in Appendix A were provided, then it should be reported in the DDD Program Services.

Q: Where do I put Room and Board fees paid by individuals? Section 3.B (under 2000 Fees)

A: For DDD Program Services, this revenue should be reported in the Client Pay account. For DDD Program Services, this revenue should be reported in the Client Pay account – 2055 under either Food or Housing (depending on the benefiting service center).

Attachment One

Q: On Attachment One, are credentials required? Section 4.A

A: Yes, credentials are required. If the individual does not have an advanced degree or specific licensure, this can be left blank. The information is valuable to us when looking at wage classification and salary data for development of reimbursement models.

Q: Will there be a problem if I report more than 2080 hours for an employee on Attachment One? Section 4.1.A

A: No. Report the total number of hours that an employee was paid for the reporting period. The information is valuable to us when looking at wage data. Example: It is leap year so there would be more hours to be paid. Do not limit the hours to 2080; report the total number of hours that the employee was paid for the reporting period.

Q: Are position numbers required? Section 4.1.A

A: Yes, position numbers are necessary for DHS to calculate an accurate turnover percentage. Position numbers do not need to be the same from year to year.

Q: How does DHS calculate turnover?

A: Turnover percentages are calculated by determining the number of persons who vacated a position divided by the total number of unduplicated positions.

EXAMPLES OF COST ALLOCATION METHODS

Following are examples of methods agencies have implemented to track and allocate costs.

Personnel

- Direct care staff performs periodic or continuous time studies. This ranges from informal, periodic time studies, to regularly scheduled (one month each quarter) or continuous (electronic time cards).
- Support staff perform time studies (i.e. typist) or are allocated based on the number of appointments made to the specific service center (i.e. receptionist), or the number of insurance billings processed.

Maintenance, Janitorial, etc.

- Costs are allocated based on square footage. Each room or area of a building is measured to determine square footage and its percent of the whole. Costs are allocated based on those percentages. For example, if IOP services are provided in 10% of the building, then 10% of the costs associated with the common areas are allocated to IOP as well.

Professional fees and contract services

- Costs are directly allocated to the benefiting service center.
- Some items, such as audit costs and some computer services, are reported in Admin and Support.

Travel

- Travel logs are maintained in agency vehicles. Staff record the number of miles and the service(s) provided. This information is used to allocate costs.
- Gas receipts are labeled with the services provided during the travel. Expenditures are then allocated to the appropriate service center. Maintenance, depreciation, insurance and licensing costs are allocated in the same way.

Supplies

- Agencies code postage and copy machines for each service center.
- Major supplies, such as paper, are tracked to a service center. Other supplies are allocated to the benefiting service center when possible.

Occupancy (utilities, rent, etc.)

- Cost allocations are based on square footage as detailed above.

Phone

- Agencies use calling codes for long distance costs.
- Local calls and fees are allocated the same as other occupancy costs or by the number of FTE.

Depreciation

- Building depreciation is allocated similar to other occupancy costs (square footage).
- Equipment depreciation is direct assignment to the benefiting service center or if it is immaterial, it is reported in Admin and Support.